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FY 17–18
MEDI-CAL SPECIALTY MENTAL HEALTH EXTERNAL QUALITY REVIEW

LAKE MHP FINAL REPORT

Prepared for:

California Department of Health Care Services (DHCS)

Review Dates:

August 16, 2017

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LAKE MHP SUMMARY OF FINDINGS

Beneficiaries served in CY16 — 1,054

MHP Threshold Language — Spanish

MHP Size — Small

MHP Region — Superior

MHP Location — Lucerne

MHP County Seat — Lakeport

Introduction

Lake County Behavioral Health includes both specialty mental health and substance abuse services. The MHP has two service locations in Lucerne and Clearlake where they provide outpatient services, crisis stabilization, case management, and medication services to children and adults. The MHP's administrative offices are located in Lucerne. The MHP has three county-operated wellness centers and one transitional-age youth wellness center operated by a contract provider. The MHP has neither a crisis stabilization unit nor a psychiatric health facility. Primary concerns for the MHP's consumer population are generational poverty, trauma and toxic stress, and drug addiction.

During the FY17-18 review, California External Quality Review Organization (CalEQRO) reviewers found the following overall significant changes, efforts, and opportunities related to access, timeliness, quality, and outcomes of the Mental Health Plan (MHP) and its contract provider services. Further details and findings from EQRO-mandated activities are provided in this report.

Access

The MHP continues to have staffing shortages in both clinical and administrative positions. Some stakeholders reported on the negative impact of ongoing vacancies, including decreased outpatient services, increased hospitalizations and placements, disruption in medication services, and increased crisis and law enforcement involvement. Other stakeholders reported an improvement or stabilization in access despite the ongoing

vacancies. Both are perceptions of the MHP's access that could be confirmed or dispelled with empirical data and evaluation of the MHP's capacity, which the MHP has yet to do.

Timeliness

The MHP has not systemically monitored timeliness to services in the past year. Monitoring of timeliness and data analytics, more generally, have been casualties of the turnover in administrative and quality management staff.

Quality

Rebuilding and establishing a functional quality management department has been an ongoing challenge for the MHP in the past few years. It seems that new leadership (i.e., the new interim director and new administrative deputy director) have made quality management a priority, beginning with reallocating and hiring dedicated analysts for mental health. The MHP has also contracted with a consultant to provide guidance on performance improvement projects, the quality improvement work plan, and other formal quality improvement activities. The MHP must commit themselves, including all levels of staff and external stakeholders, to improving their mechanisms for monitoring and delivering quality care.

Outcomes

A large positive impact on consumer outcomes is the MHP's staff. A team approach was mentioned often as contributing to consumer's progress and success. Teams consisted of both veteran staff with years of experience and strong skill sets, and new staff with an interest in learning and supporting clients. In addition to using formal outcome instruments, the staff were amenable and welcomed other outcome measures that would provide more frequent assessments of outcomes.

INTRODUCTION

The United States Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review (EQR) is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by Prepaid Inpatient Health Plans (PIHPs) and their contractors to recipients of State Medicaid managed care services. The CMS (42 CFR §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rules specify the requirements for evaluation of Medicaid managed care programs. These rules require an on-site review or a desk review of each Medi-Cal Mental Health Plan (MHP).

The State of California Department of Health Care Services (DHCS) contracts with 56 county Medi-Cal MHPs to provide Medi-Cal covered specialty mental health services (SMHS) to Medi-Cal beneficiaries under the provisions of Title XIX of the federal Social Security Act.

This report presents the fiscal year 2017-2018 (FY17-18) findings of an EQR of the Lake MHP by the California External Quality Review Organization (CalEQRO), Behavioral Health Concepts, Inc. (BHC).

The EQR technical report analyzes and aggregates data from the EQR activities as described below:

Validation of Performance Measures[1]

Both a statewide annual report and this MHP-specific report present the results of CalEQRO's validation of eight mandatory performance measures (PMs) as defined by DHCS. The eight PMs include:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;

[1] *Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Protocol 2, Version 2.0, September, 2012. Washington, DC: Author.*

- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4% *Emily Q.* Benchmark[2];
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS);
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day Specialty Mental Health Services (SMHS) follow-up service rates; and
- High-Cost Beneficiaries (HCBs), incurring approved claims of $30,000 or higher during a calendar year.

Performance Improvement Projects[3]

Each MHP is required to conduct two performance improvement projects (PIPs)—one clinical and one non-clinical—during the 12 months preceding the review. The PIPs are discussed in detail later in this report.

MHP Health Information System Capabilities[4]

Using the Information Systems Capabilities Assessment (ISCA) protocol, CalEQRO reviewed and analyzed the extent to which the MHP meets federal data integrity requirement for Health Information Systems (HIS), as identified in 42 CFR §438.242. This evaluation included a review of the MHP's reporting systems and methodologies for calculating PMs.

Validation of State and County Consumer Satisfaction Surveys

CalEQRO examined available consumer satisfaction surveys conducted by DHCS, the MHP, or its subcontractors.

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[2] The *Emily Q.* lawsuit settlement in 2008 mandated that the MHPs provide TBS to foster care children meeting certain at-risk criteria. These counts are included in the annual statewide report submitted to DHCS, but not in the individual county-level MHP reports.

[3] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). Validating Performance Improvement Projects: Mandatory Protocol for External Quality Review (EQR), Protocol 3, Version 2.0, September 2012. Washington, DC: Author.

[4] Department of Health and Human Services. Centers for Medicare and Medicaid Services (2012). EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Protocol 1, Version 2.0, September 1, 2012. Washington, DC: Author.

CalEQRO also conducted 90-minute focus groups with beneficiaries and family members to obtain direct qualitative evidence from beneficiaries.

Review of Recommendations and Assessment of MHP Strengths and Opportunities

The CalEQRO review draws upon prior years' findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management — emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for key components associated with the following three domains: access, timeliness, and quality. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups, beneficiaries, and other stakeholders inform the evaluation of the MHP's performance within these domains. Detailed definitions for each of the review criteria can be found on the CalEQRO Website, www.caleqro.com.

PRIOR YEAR REVIEW FINDINGS, FY17-18

In this section, the status of last year's (FY16-17) recommendations are presented, as well as changes within the MHP's environment since its last review.

Status of FY16–17 Review of Recommendations

In the FY16-17 site review report, the CalEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During the FY17-18 site visit, CalEQRO and MHP staff discussed the status of those FY16-17 recommendations, which are summarized below.

Assignment of Ratings

Met is assigned when the identified issue has been resolved.

Partially Met is assigned when the MHP has either:

- Made clear plans and is in the early stages of initiating activities to address the recommendation; or
- Addressed some but not all aspects of the recommendation or related issues.

Not Met is assigned when the MHP performed no meaningful activities to address the recommendation or associated issues.

Key Recommendations from FY16-17

Recommendation #1: Re-establish a functional quality improvement program that has regular meetings and broad stakeholder participation, and that collects, regularly reviews, and utilizes data on service provision, as related to quality, timeliness, and access to care.

Status: **Partially Met**

- The MHP has established regular, quarterly, quality improvement committee (QIC) meetings. The MHP has had four such meetings since the last external quality review.
- The MHP participation in the QIC consists primarily of leadership, with little participation by supervisory or line staff. Meeting minutes show increasing stakeholder participation, particularly from contract providers.

- Per the minutes, the QIC meetings often covered compliance (e.g., grievances) and updates of MHP activities, but there was little review of service provision or

other data that related to access, timeliness, or quality of services. With the addition of two analysts to the QI department, the MHP is better positioned to do this going forward.

Recommendation #2: Develop and initiate one clinical and one non-clinical Performance Improvement Project (PIP).

Status: **Not Met**

- The MHP has not implemented either a clinical PIP or a non-clinical PIP. The MHP presented a concept for a clinical PIP, which requires preliminary or baseline data to justify the need for the PIP.
- The MHP cited a number of factors as contributing to the lack of PIPs: turnover and under-staffing in QI; competing priorities (e.g., renewal of Mental Health Services Act proposal and remediation of cost reporting); and, new staff who were still learning QI processes and how to develop PIPs.
- The MHP contracted with a consulting agency, in July 2017, to assist with the development and implementation of both a clinical and non-clinical PIP.

Recommendation #3: Upgrade server to enable enhanced functionality of the electronic health record (EHR), including the ability to incorporate progress notes and client signature and enable full document imaging.

Status: **Met**

- The MHP collaborated extensively with its vendor, Cerner, to assess their needs and remediation efforts to bring the server hardware to an acceptable performance level for the Cerner Community Behavioral Health EHR. The remediation went live in spring 2017, per the agreed upon specifications.
- The MHP submitted performance testing documentation to demonstrate to CalEQRO the real-time benefits of this project. The MHP presented substantial end-user benefits.

Recommendation #4: Evaluate and standardize measures of timeliness to services and then monitor and report each component on a quarterly basis.

Status: **Not Met**

- The MHP has not been tracking and reporting timeliness of services systemically. Individual systems of care (e.g., children's) and programs tracked and reported timeliness, but they were unaware of its use and where this data ultimately ended up.

- The MHP reported on the rate of rehospitalization, but otherwise did not present any other timeliness data on CalEQRO's Self-Assessment of Timely Access tool.
- The MHP stated that they are evaluating the capabilities of the EHR, Anasazi, to generate various timeliness reports.

Recommendation #5: Survey or obtain feedback and recommendations from at least 10 percent of consumers about/on MHP's services and programs, similar to the content of the External Quality Review (EQR) focus group. The MHP must use a mechanism that ensures confidentiality and anonymity of new and pre-existing consumers who participate in the survey.

Status: **Not Met**

- The MHP cited their participation in the twice yearly Consumer Perception Survey (CPS) and an increase in consumer participation in November 2016 (i.e., compared to May 2016) as their effort to obtain consumer feedback.
- While CalEQRO acknowledges the MHP's efforts to increase participation, 23 consumers is, at most, only 2.4% of the MHP's consumer population and does not provide the MHP with broad consumer input of services in the past year.
- The MHP reported current use of suggestion boxes, with anonymous submission, and future plans to use survey kiosks at clinics to obtain consumer input.

Changes in the MHP Environment and Within the MHP—Impact and Implications

Discussed below are any changes since the last CalEQRO review that were identified as having a significant effect on service provision or management of those services. This section emphasizes systemic changes that affect access, timeliness, and quality, including any changes that provide context to areas discussed later in this report.

Access to Care

- The MHP has not had stable or consistent outpatient services as a result of turnover and vacancies in clinical staff positions. Stakeholders pointed to the increase in placements and increased involvement of community agencies (e.g., sheriff and jails) as evidence of decreased outpatient capacity.
- The MHP stopped 24-hour crisis coverage in May 2017 because of limited staffing. Crisis services now conclude at midnight, with crisis calls diverted to Alameda Crisis Line, and resume at 8:00am. The MHP leadership indicated that 24-hour crisis would resume in the upcoming two to three weeks with the hire of five new crisis staff.
- Despite the continued staffing challenges, consumers remarked on improved access to services, although no particular change was referenced.

Timeliness of Services

- The turnover in administrative staff, particularly in QI, has disrupted the MHP's ability to track timeliness of services. While staff may have a sense of timeliness, overall, the MHP was not in a position to know if they are providing timely services and what, if anything, they need to do to improve it.

Quality of Care

- Because of the turnover of staff—and lack of succession planning—much of the protocols for data collection and processes for program review have ceased.
- The vacancies and aftermath of fires have required the MHP to rely on community-based partners and agencies to fill some gaps. The MHP has used this opportunity to enhance and/or formalize collaboration. The MHP has partnered with probation to improve the coordination of mental health care for children in custody. The MHP is collaborating with housing agencies to

address housing shortages and identify feasible housing options for consumers and staff alike.

- One impact of the staffing shortage, particularly of medication technicians, has been inefficient medication services. Processing of medications, answering of telephones, and documentation have been adversely affected.

Consumer Outcomes

- A new staff service analyst facilitated the analyses of completed CPS surveys, which gives the MHP more immediate access to survey findings and an opportunity to address areas of consumer dissatisfaction.

PERFORMANCE MEASUREMENT

As noted above, CalEQRO is required to validate the following PMs as defined by DHCS:

- Total beneficiaries served by each county MHP;
- Total costs per beneficiary served by each county MHP;
- Penetration rates in each county MHP;
- Count of TBS Beneficiaries Served Compared to the 4% *Emily Q.* Benchmark (not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS);
- Total psychiatric inpatient hospital episodes, costs, and average LOS;
- Psychiatric inpatient hospital 7-day and 30-day rehospitalization rates;
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates; and
- HCBs incurring $30,000 or higher in approved claims during a calendar year.

HIPAA Suppression Disclosure:

Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Total Beneficiaries Served

Table 1 provides detail on beneficiaries served by race/ethnicity.

Table 1: Lake MHP Medi-Cal Enrollees and Beneficiaries Served in CY16, by Race/Ethnicity				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count of Beneficiaries Served**	**% Served**
White	20,268	62.4%	739	70.1%
Latino/Hispanic	7,060	21.7%	115	10.9%
African-American	830	2.6%	45	4.3%
Asian/Pacific Islander	468	1.4%	*	n/a
Native American	1,193	3.7%	*	n/a
Other	2,680	8.2%	111	10.5%
Total	**32,497**	**100%**	**1,054**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

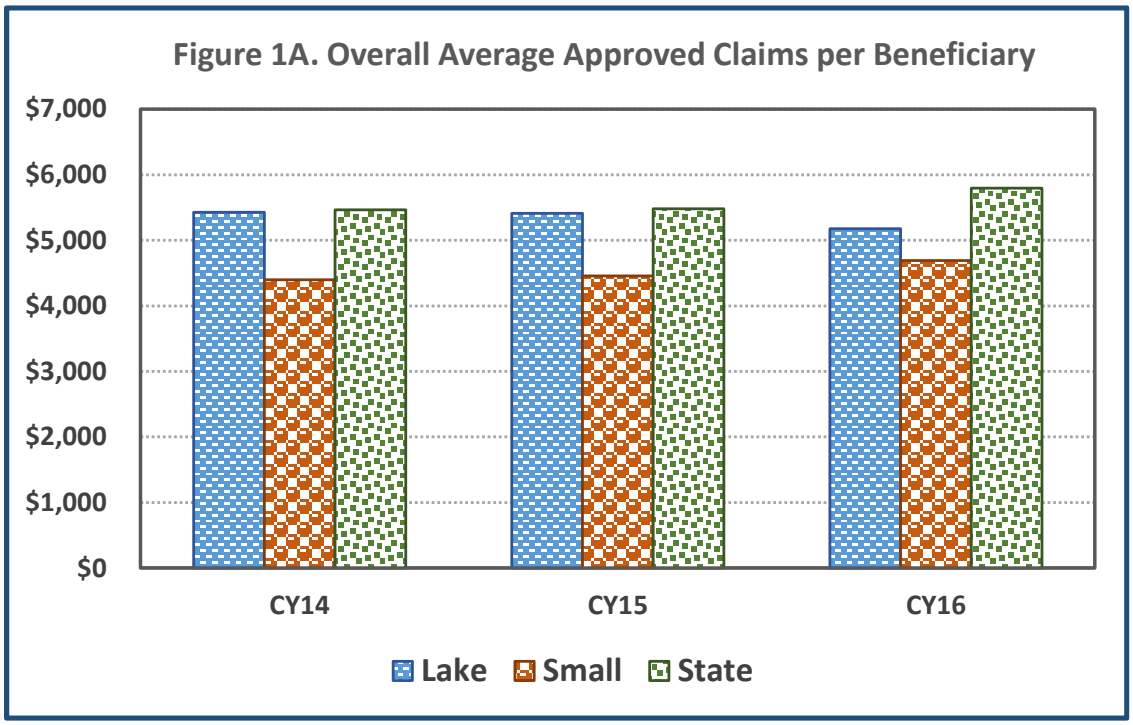
Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served. See Attachment C, Table C1 for the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary.

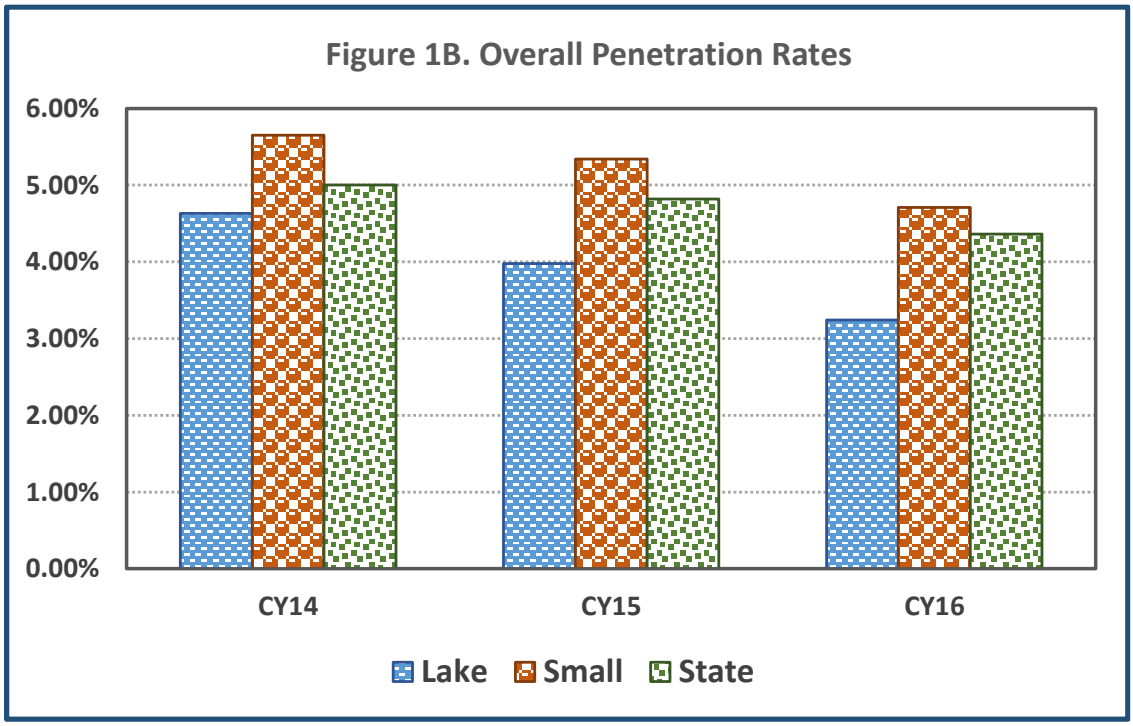
Penetration Rates and Approved Claim Dollars per Beneficiary

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average enrollee count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year.

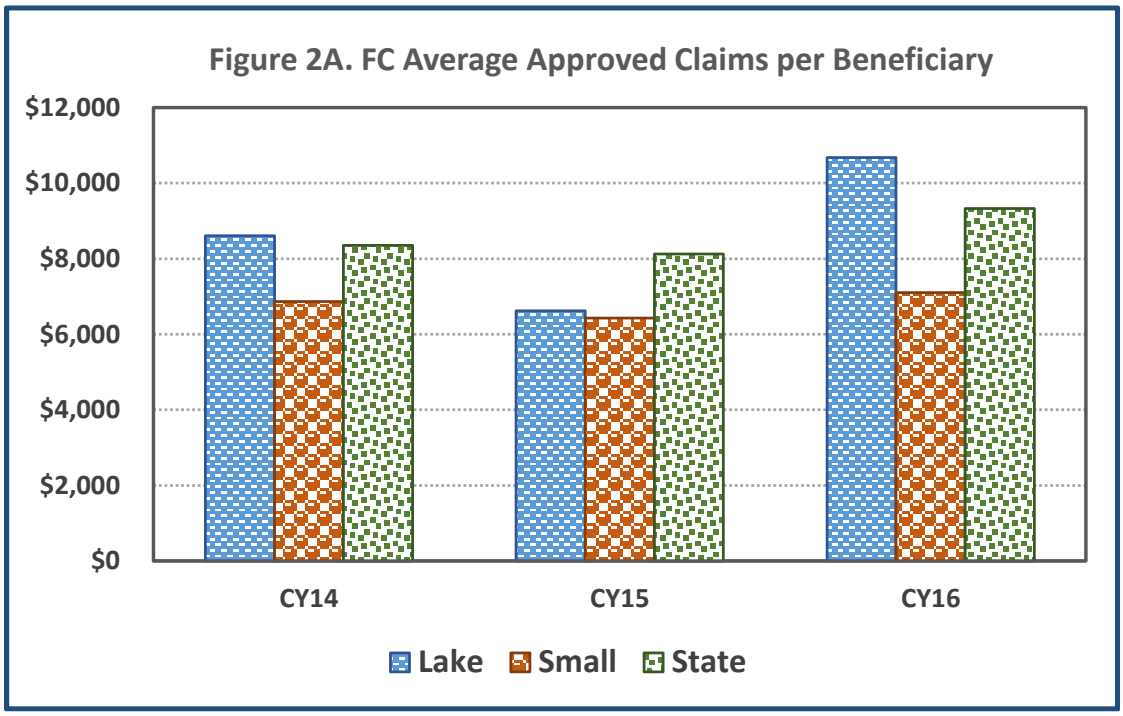
Regarding calculation of penetration rates, the Lake MHP uses a different method.

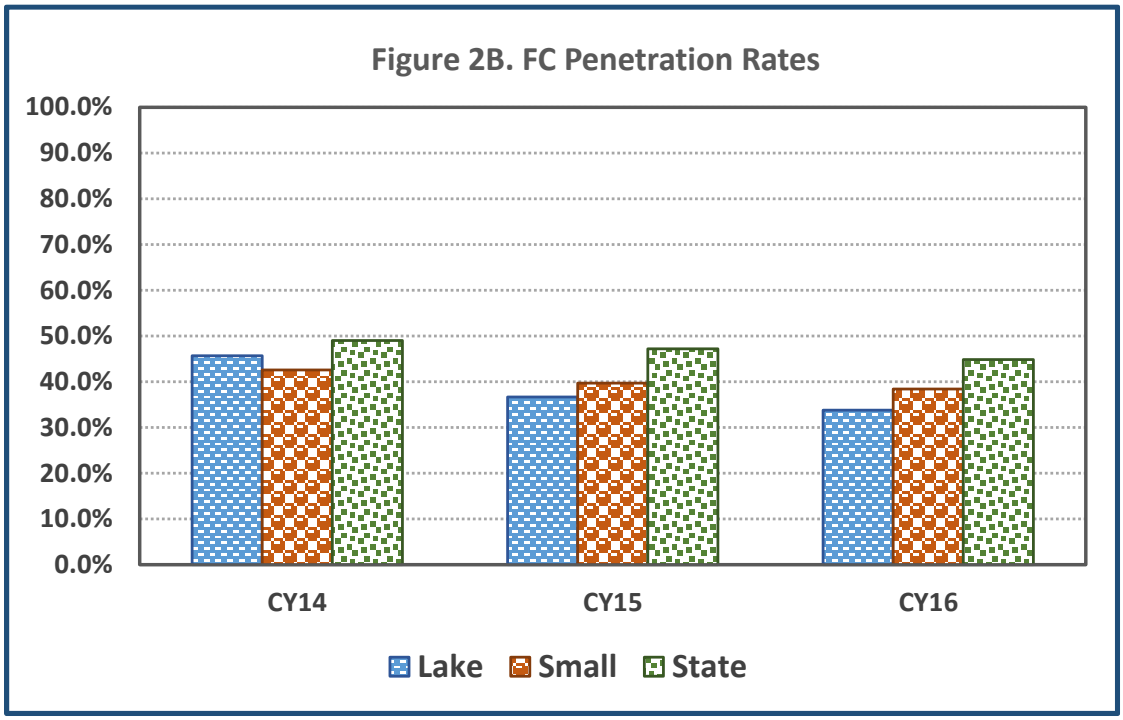
Figures 1A and 1B show 3-year (CY14-16) trends of the MHP's overall approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.



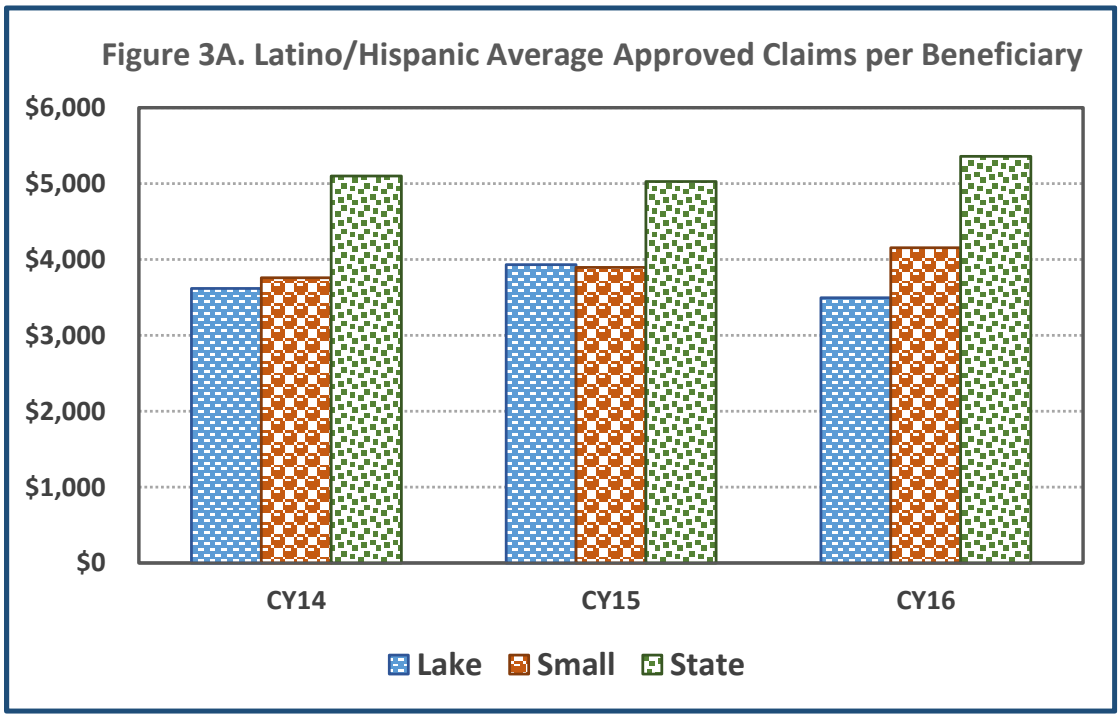


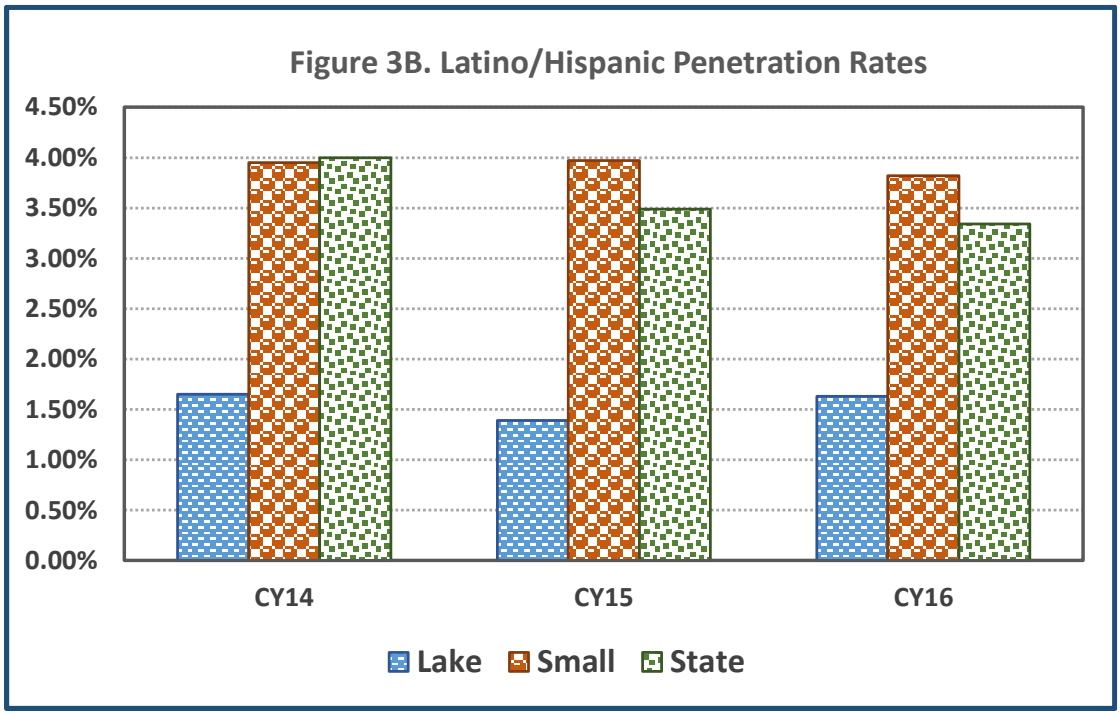
Figures 2A and 2B show 3-year (CY14-16) trends of the MHP's foster care (FC) approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.





Figures 3A and 3B show 3-year (CY14-16) trends of the MHP's Latino/Hispanic approved claims per beneficiary and penetration rates, compared to both the statewide average and the average for small MHPs.





High-Cost Beneficiaries

Table 2 compares the statewide data for High-Cost Beneficiaries (HCBs) for CY16 with the MHP's data for CY16, as well as the prior two years. HCBs in this table are identified as those with approved claims of more than $30,000 in a year.

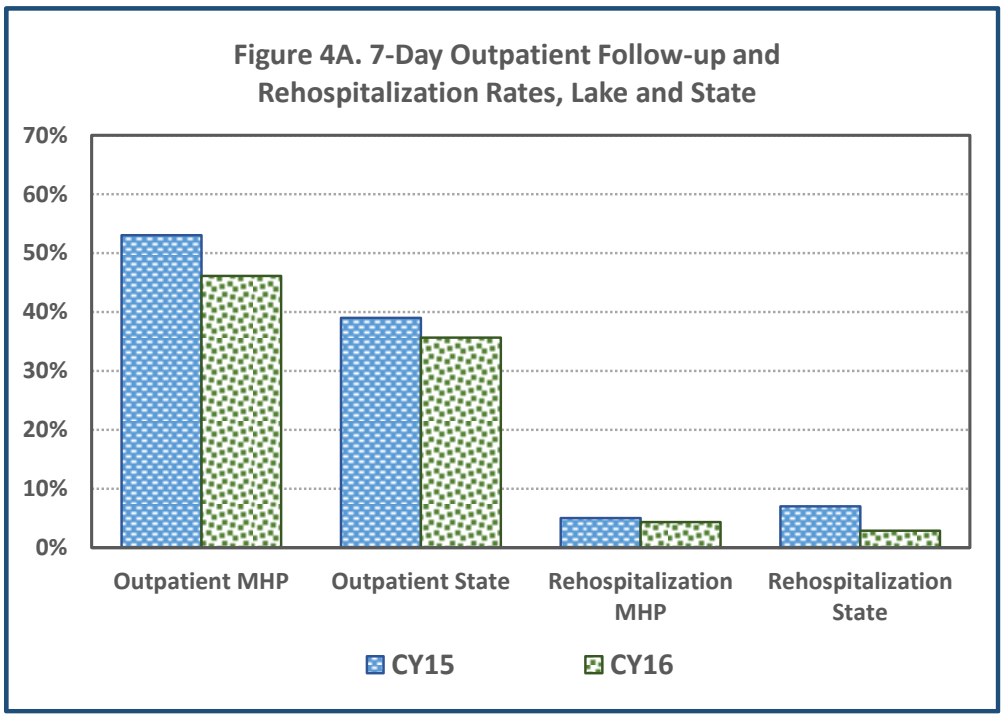
Table 2: Lake MHP High-Cost Beneficiaries

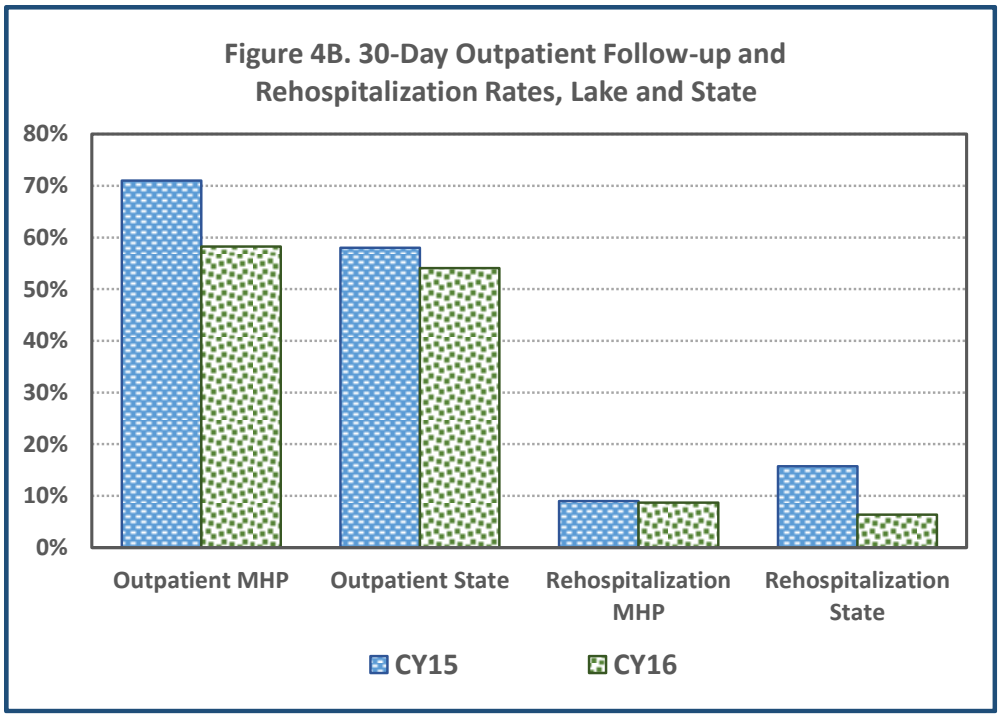
MHP	Year	HCB Count	Total Beneficiary Count	HCB % by Count	Average Approved Claims per HCB	HCB Total Claims	HCB % by Approved Claims
Statewide	CY16	18,909	598,296	3.16%	$53,219	$1,006,318,438	29.02%
Lake	CY16	28	1,054	2.66%	$51,158	$1,432,413	26.27%
	CY15	29	941	3.08%	$44,850	$1,300,636	25.55%
	CY14	24	1,031	2.33%	$42,290	$1,014,961	22.21%

See Attachment C, Table C2 for the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000; and those above $30,000.

Timely Follow-up After Psychiatric Inpatient Discharge

Figures 4A and 4B show the statewide and MHP 7-day and 30-day outpatient follow-up and rehospitalization rates for CY15 and CY16.

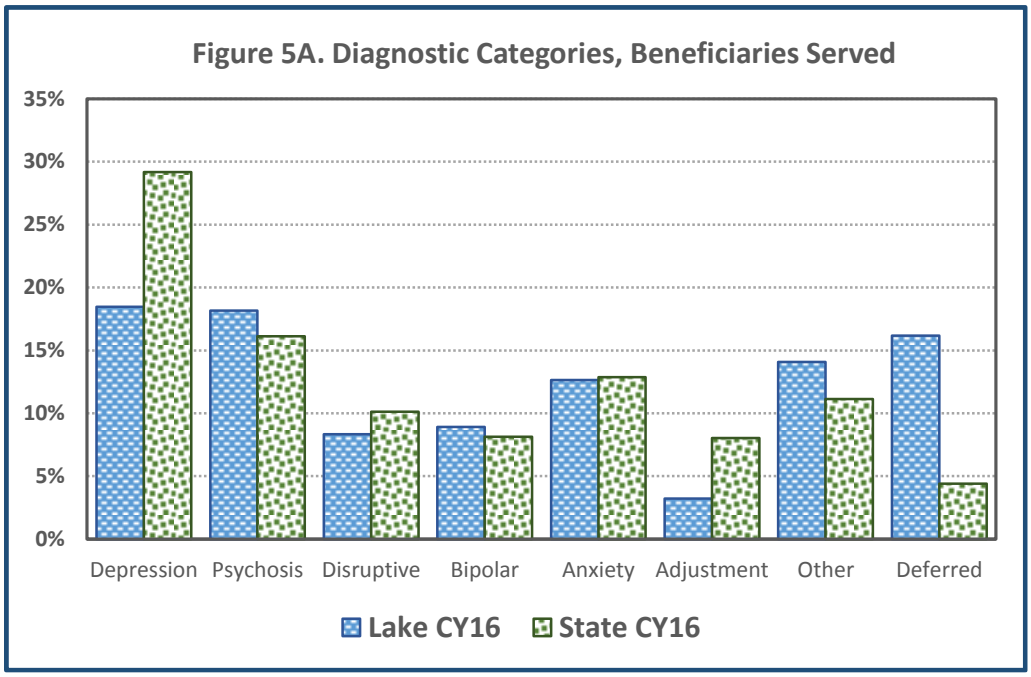


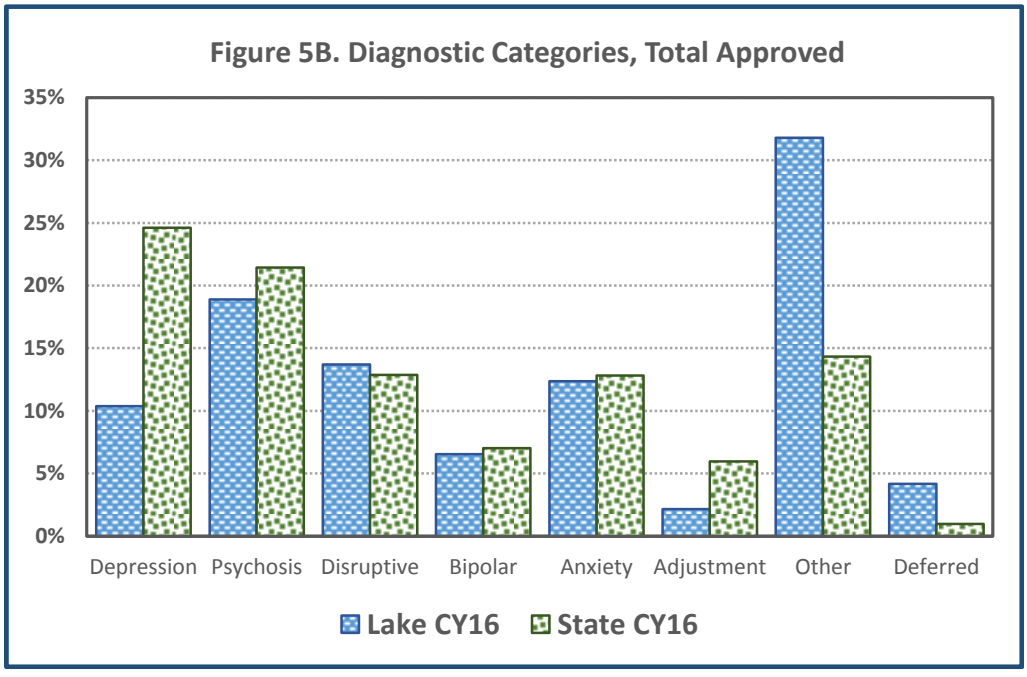


Diagnostic Categories

Figures 5A and 5B compare the breakdown by diagnostic category of the statewide and MHP number of beneficiaries served and total approved claims amount, respectively, for CY16.

MHP self-reported percent of consumers served with co-occurring (substance abuse and mental health) diagnoses: 14%.





Performance Measures Findings—Impact and Implications

Access to Care

- The MHP's number of eligibles, including ACA expansion beneficiaries, rose from 30,899 in CY15 to 39,497 in CY16. The number of beneficiaries served decreased from 1,150 in CY15 to 1,054 in CY16.
- The MHP's number of eligible Foster Care beneficiaries decreased from 207 in CY15 to 204 in CY16. The number of Foster Care beneficiaries served also decreased from 76 in CY15 to 69 in CY16.
- The MHP's number of eligible Latino/Hispanic beneficiaries, including ACA expansion beneficiaries, rose from 6,250 in CY15 to 7,060 in CY16. The number of Latino/Hispanic beneficiaries served rose from 89 in CY15 to 115 in CY16.

Timeliness of Services

- The MHP's 7-day and 30-day follow-up rates are higher than the statewide averages.

Quality of Care

- The MHP's percentage of high-cost beneficiaries and the corresponding percentage of total approved claims are both lower than statewide percentages.
- The MHP has a higher percentage of psychosis, other, and deferred diagnoses than statewide, and a lower percentage of all other categories than statewide.

Consumer Outcomes

- The MHP experienced higher 7- and 30-day psychiatric rehospitalization rates in CY16 compared to State.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

A Performance Improvement Project (PIP) is defined by CMS as "a project designed to assess and improve processes and outcomes of care that is designed, conducted, and reported in a methodologically sound manner." The Validating Performance Improvement Projects Protocol specifies that the EQRO validate two PIPs at each MHP that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. DHCS elected to examine projects that were underway during the preceding calendar year.

Lake MHP PIPs Identified for Validation

Each MHP is required to conduct two PIPs during the 12 months preceding the review. CalEQRO reviewed and validated one MHP-submitted PIP, as shown below.

Table 3 lists the findings for each section of the evaluation of the PIPs, as required by the PIP Protocols: Validation of Performance Improvement Projects.[5]

Table 3: PIPs Submitted by Lake MHP

PIPs for Validation	# of PIPs	PIP Titles
Clinical PIP	1	Transition Team
Non-clinical PIP	0	The MHP did not submit a non-clinical PIP

Table 4, on the following page, provides the overall rating for each PIP, based on the ratings given to the validation items: Met (M), Partially Met (PM), Not Met (NM), Not Applicable (NA), Unable to Determine (UTD), or Not Rated (NR).

[5] *2012 Department of Health and Human Services, Centers for Medicare and Medicaid Service Protocol 3 Version 2.0, September 2012. EQR Protocol 3: Validating Performance Improvement Projects.*

Table 4: PIP Validation Review					
Step		PIP Section	Validation Item	Item Rating	
					Non-Clinical
1	Selected Study Topics	1.1	Stakeholder input/multi-functional team	NR	NR
		1.2	Analysis of comprehensive aspects of enrollee needs, care, and services	NR	NR
		1.3	Broad spectrum of key aspects of enrollee care and services	NR	NR
		1.4	All enrolled populations	NR	NR
2	Study Question	2.1	Clearly stated	NR	NR
3	Study Population	3.1	Clear definition of study population	NR	NR
		3.2	Inclusion of the entire study population	NR	NR
4	Study Indicators	4.1	Objective, clearly defined, measurable indicators	NR	NR
		4.2	Changes in health status, functional status, enrollee satisfaction, or processes of care	NR	NR
5	Sampling Methods	5.1	Sampling technique specified true frequency, confidence interval and margin of error	NR	NR
		5.2	Valid sampling techniques that protected against bias were employed	NR	NR
		5.3	Sample contained sufficient number of enrollees	NR	NR
6	Data Collection Procedures	6.1	Clear specification of data	NR	NR
		6.2	Clear specification of sources of data	NR	NR
		6.3	Systematic collection of reliable and valid data for the study population	NR	NR
		6.4	Plan for consistent and accurate data collection	NR	NR
		6.5	Prospective data analysis plan including contingencies	NR	NR
		6.6	Qualified data collection personnel	NR	NR
7	Assess Improvement Strategies	7.1	Reasonable interventions were undertaken to address causes/barriers	NR	NR
8	Review Data Analysis and Interpretation of Study Results	8.1	Analysis of findings performed according to data analysis plan	NR	NR
		8.2	PIP results and findings presented clearly and accurately	NR	NR
		8.3	Threats to comparability, internal and external validity	NR	NR
		8.4	Interpretation of results indicating the success of the PIP and follow-up	NR	NR
9	Validity of Improvement	9.1	Consistent methodology throughout the study	NR	NR
		9.2	Documented, quantitative improvement in processes or outcomes of care	NR	NR
		9.3	Improvement in performance linked to the PIP	NR	NR
		9.4	Statistical evidence of true improvement	NR	NR
		9.5	Sustained improvement demonstrated through repeated measures.	NR	NR

Table 5 provides a summary of the PIP validation review.

Table 5: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met		
Number Partially Met		
Number Not Met		
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)		
Overall PIP Rating ((#Met*2)+(#Partially Met))/(AP*2)	**0%**	**0%**

Clinical PIP—Transition Team

The MHP presented its study question for the clinical PIP as follows:

"Would creation of a multi-disciplinary team facilitate connection to and engagement in identified services such that a conserved client returning from an out-of-county IMD placement or a Board and Care or a high user of hospitalizations, result in increased stability within the community as measured by a reduction in hospitalizations for the client and an increased participation in services?"

Date PIP began: January 2017

Status of PIP: Concept only, not yet active (not rated)

One of the effects of vacancies in staffing was that transition to services and the community was not occurring or occurring consistently for Lake County consumers returning after out-of-county placements. The MHP identified decompensation and increase in rehospitalization as an effect of inadequate transition support. The MHP also identified that consumers who had frequent hospitalizations, defined as two or more in 30 days, would also benefit from transition support. The MHP developed a PIP to coordinate services for (1) conserved consumers returning to Lake County, and (2) consumers with frequent hospitalizations. The MHP's intervention is to convene and provide a multi-disciplinary team to facilitate client's connection to services. The multi-disciplinary transition team would include a housing coordinator, a discharge planner, a medication case manager, public guardians, and a clinician. The MHP did not explicitly state their intervention(s), but they appear to include twice monthly meetings to discuss pending discharges, assignment of a staff/team member to coordinate linkages, and transition support for up to 45 days.

The MHP presented this PIP as a concept, but the MHP has already convened the transition team and has been coordinating linkages for clients for several months. To move this concept to an active PIP, the MHP would need to provide more detail about the project, their activities, and both retrospective and prospective data. The MHP based the project ostensibly on one case study and did not provide enough information about the extent of this issue for other clients. The PIP would benefit from more detail about the target population: the anticipated number of the total conserved clients (21) due to return to Lake County, and the number of clients with frequent hospitalizations. The MHP would also need data to substantiate that there was a link between lack of transition support and hospitalizations (and other manifestations of decompensation). The MHP would need current data (i.e., from 2016) of the hospitalization rate rather than one-year old data from July-December 2015. As the MHP continues this project, they should revise the PIP to include details regarding how transition support is to be implemented, discuss contingencies if clients decide to opt out of the support, and include other indicators that relate to timeliness and comprehensiveness of transition support.

Relevant details of these issues and recommendations are included within the comments found in the PIP validation tool.

The technical assistance provided to the MHP by CalEQRO consisted of recommendations as above and to provide relevant data to substantiate the project.

Non-clinical PIP—None Submitted

Status of PIP: No PIP submitted (not rated)

PIP Findings—Impact and Implications

Access to Care

- By convening a transition team, the MHP is improving access and facilitating continuity of care for high risk consumers at a critical time in their care.

Timeliness of Services

- The MHP stated that timeliness of supportive services for returning clients was adversely affected by lack of staffing. Thus, the transition team is meant to streamline and improve time to services. However, the MHP did not articulate how timeliness would improve and how they intend to monitor this.

- Besides the time to link to supportive services, the MHP may also consider the latency to hospitalizations as an impact of the transition team.

Quality of Care

- The transition team is meant to coordinate a variety of supports that facilitate consumer's stability in the community. The transition team reflects integrated care and incorporation of social determinants of health, which are both consistent with providing quality care.
- The project that the MHP has proposed is not yet a PIP. For the MHP to realize the potential in improving quality of care, the MHP should fully address the areas that were deficient.
- The MHP misses opportunities for focused review of services, engaging stakeholders, and improving care by not prioritizing PIPs.

Consumer Outcomes

- While the MHP alluded to a few consumer outcomes, the MHP identified only hospitalizations. There are other measures that the MHP ought to consider that reflect improved outcomes for consumers (e.g., engagement in treatment, stability in the community; latency to hospitalizations).

PERFORMANCE AND QUALITY MANAGEMENT KEY COMPONENTS

CalEQRO emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management include an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies that support system needs. These are discussed below, along with their quality rating of Met (M), Partially Met (PM), or Not Met (NM).

Access to Care

Table 6 lists the components that CalEQRO considers representative of a broad service delivery system that provides access to consumers and family members. An examination of capacity, penetration rates, cultural competency, integration, and collaboration of services with other providers forms the foundation of access to and delivery of quality services.

Table 6: Access to Care Components		
Component		**Quality Rating**
1A	Service accessibility and availability are reflective of cultural competence principles and practices	PM
The MHP implemented strategies to address the cultural, ethnic, and linguistic needs of beneficiaries, including the availability of bilingual staff and wellness centers that target particular populations (e.g., Native Americans). However, the MHP did not provide evidence of how they assess the needs of their eligibles or evaluate the efficacy or impact of their strategies.		
1B	Manages and adapts its capacity to meet consumer service needs	PM
The MHP tracks data related to caseloads, hospital utilization, and intakes. These data are maintained within the specific departments/systems of care and not collated and reviewed in aggregate. As these data seemingly did not move beyond where it was sent, the MHP has not been using it to assess their capacity relative to the clinical, cultural, and/or linguistic needs. The MHP had some strategies to provide the requisite providers: recruitment of an on-site psychiatrist; status as a loan forgiveness area; and, leadership endorsement of increased clinician salaries. The MHP has not evaluated the impact of these strategies in the past year.		
1C	Integration and/or collaboration with community-based services to improve access	M
The MHP has a number of community-based partners and agencies that facilitate integrated services for consumers and their families. The MHP provided several examples of collaboration: with local primary care clinics, hospitals, the substance use disorders program, schools, and law enforcement among others. In this past year, the MHP has collaborated with the local housing authority to replace transitional housing capacity lost to the fires.		

Timeliness of Services

As shown in Table 7, CalEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. This ensures successful engagement with consumers and family members and can improve overall outcomes, while moving beneficiaries throughout the system of care to full recovery.

Table 7: Timeliness of Services Components		
Component		**Quality Rating**
2A	Tracks and trends access data from initial contact to first appointment	NM
The MHP did not indicate their standard for this metric. The MHP does not have timeliness processes integrated into the EHR workflow. Different programs have a process for collecting this data, but the data are not aggregated. The data are sent to one place, where the information sharing ends. Staff, including leadership, were not aware of what, if anything, was done with this information. Previously, manual data collection processes used by the QI department have proved fragile and were not resumed by the new QI staff members.		

2B	Tracks and trends access data from initial contact to first psychiatric appointment	NM
The MHP did not indicate their standard for first psychiatric appointment. The MHP did not monitor this metric and therefore did not evaluate performance or initiate performance improvement activities relative to this metric.		
2C	Tracks and trends access data for timely appointments for urgent conditions	NM
The MHP did not indicate their standard for urgent conditions. The MHP did not monitor this metric and therefore did not evaluate performance or initiate performance improvement activities relative to this metric.		
2D	Tracks and trends timely access to follow-up appointments after hospitalization	NM
The MHP did not indicate their standard for follow-up appointments after hospitalization; however, elsewhere the MHP referenced their Recent Discharge High Triage program that is meant to provide follow-up appointments within 5 to 10 days. The MHP did not monitor this metric and therefore did not evaluate performance or initiate performance improvement activities relative to this metric.		
2E	Tracks and trends data on rehospitalizations	PM
The MHP tracked and reported on their rehospitalizations within 30 days. The MHP reported a rehospitalization rate of 1%. The MHP initiated an activity (see PIP) to improve/decrease the readmission rate for conserved and high-need consumers with multiple admissions, but the basis or rationale for this activity is not clear as their readmission rate is very low.		
2F	Tracks and trends no-shows	NM
The MHP neither provided data on this metric nor did any MHP staff mentioned any efforts to monitor or improve no-shows.		

Quality of Care

In Table 8, CalEQRO identifies the components of an organization that is dedicated to the overall quality of care. Effective quality improvement activities and data-driven decision making require strong collaboration among staff (including consumer/family member staff), working in information systems, data analysis, clinical care, executive management, and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Table 8: Quality of Care Components

Component		Quality Rating
3A	Quality management and performance improvement are organizational priorities	NM

Table 8: Quality of Care Components		
Component		**Quality Rating**
Much of the quality management (QM) department and QI functions are in flux. With the departure of QM staff in 2016, the MHP has not resumed a full complement of QM activities. Besides the reinstatement of QI meetings in the past year, other QI activities have languished. However, the MHP is in the process of rebuilding their QM structure and staffing, starting with hiring and allocation of analysts to compliance and QM for mental health (and not only AOD). The MHP anticipates completion of the evaluation of the FY16-17 QI work plan and development of the FY17-18 work plan within the upcoming months once new staff are oriented to their positions and roles.		
3B	Data are used to inform management and guide decisions	NM
The MHP has not structured its QI Plan to include benchmarks, quantifiable goals with longitudinal measurement, and analysis to formulate change. The FY16-17 QI Plan focused more on mandated compliance components and less on (clinical) quality improvements. The MHP monitored consumer outcomes and satisfaction. The staff analyst in the QM department collected and reviewed results of the CPS survey and was able to speak to the areas that needed improvement (i.e., access to psychiatry). The MHP also conducted some quality improvement activities, but did not develop or document their progress and activities or systematically track outcomes.		
3C	Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation	PM
Line staff and supervisors remarked that communication was improving, particularly with the new director, and that there was an effort to be more transparent. Contract providers also expressed optimism that new management was making an effort to improve collaboration and transparency, but also expressed interest in increased collaboration in fiscal transparency, program innovation, and quality improvement. Staff also had some reservations about their feedback being taken seriously. Of note is that staff were not involved in decision-making or system-planning meetings. Consumers and family stakeholders had positive responses regarding service navigation, but did not appear to be involved in system planning and decision-making activities.		
3D	Evidence of a systematic clinical continuum of care	PM
The MHP has a number of services that related to behavioral health promotion, prevention, treatment, and recovery. The MHP is planning to restore their crisis response to 24-hour coverage. The MHP coordinates with other counties for placements for youth and for hospitalizations. Staff reported that inadequate outpatient services has negatively affected crisis and hospitalizations. In general, the MHP's ability to monitor these services routinely and modify capacity were limited by a skeleton QM department. The MHP does not use level of care tools per se; however, clinicians use outcome instruments (e.g., CANS, MORS, a Centers for Disease Control *Healthy Days Questionnaire*, and some others).		

Table 8: Quality of Care Components		
Component		**Quality Rating**
3E	Evidence of consumer and family member employment in key roles throughout the system	PM
The MHP has paid positions specifically dedicated for consumers and family members at the wellness centers. These peer positions include supervisory roles and entry-level positions that have opportunities for advancement. There was no evidence that the peer positions extended or reported to the executive management team.		
3F	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	PM
The MHP has four wellness centers. The wellness center in Lakeport, visited by CalEQRO, appeared to have experienced cutbacks in services and activities, and was no longer active or vibrant. However, there was evidence that the wellness center was in the process of recapturing the level of community participation it once enjoyed. Activities were in motion to ensure 33% consumer employment.		
3G	Measures clinical and/or functional outcomes of consumers served	PM
The MHP collected consumer-level data for sub-populations and programs (e.g., CANS for Katie A., Data Collection Reporting for MHSA programs, and other outcome measures for full service partnership (FSP) programs). While staff used various outcome measures for evaluating treatment, none were used systemically. The MHP does not collect outcomes data geared toward system-wide evaluation and the MHP does not have the capacity to utilize its outcomes measures as longitudinal Level of Service/Level of Care tools to assess service quality and determine if consumers are getting better.		
3H	Utilizes information from Consumer Satisfaction Surveys	PM
The MHP conducts surveys routinely at the wellness centers. These are used for pre- and post-services satisfaction of consumers. The MHP presented the results and their analysis of CPS from November 2016. The survey was not representative of the MHP's consumer population, but the MHP is using the findings to address areas of concern for consumers. The results were shared with some of the MHP leadership, but had yet to be shared with staff and contract providers. The director indicated that the results would be shared at the next All Staff meeting.		

Key Components Findings—Impact and Implications

Access to Care

- The MHP implemented strategies to serve diverse consumer populations; however, the MHP did not use objective data to support those strategies. Similarly, the MHP has not used data to evaluate the impact of those strategies and the need to modify them to increase access.
- Stakeholders reported that the MHP's capacity to provide outpatient services have been curtailed by a shortage of staff, resulting in increased need for crisis services and placements.
- The MHP has leveraged their partnerships and contract providers to facilitate access to care for consumers.

Timeliness of Services

- As the MHP did not track or monitor timeliness to services over the past year, CalEQRO considered stakeholder's perception and input on timeliness. Stakeholders did not report any untoward aspects of timeliness for MHP services.

Quality of Care

- The MHP's QM department has not been staffed sufficiently in the past year to enable regular review and evaluation of services and other data-intensive activities.
- The MHP's new leadership has ushered in improved communication with stakeholders.
- At present, communication is related to disseminating and sharing information, which has improved transparency, but has yet to include stakeholders in decision making.
- The MHP has a continuum of care that includes peers and values their role in wellness and recovery.

Consumer Outcomes

- The MHP has not invested in systemic outcome measures for either the adults or children's systems of care, but staff reported use of a variety of validated outcome measures to assess consumer outcomes.

CONSUMER AND FAMILY MEMBER FOCUS GROUP

CalEQRO conducted one 90-minute focus group with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CalEQRO requested one focus groups with 8 to 10 participants each, the details of which can be found in each section below.

The consumer/family member focus group is an important component of the CalEQRO site review process. Obtaining feedback from those who are receiving services provides significant information regarding quality, access, timeliness, and outcomes. The focus group questions are specific to the MHP being reviewed and emphasize the availability of timely access to care, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CalEQRO provides gift certificates to thank the consumers and family members for their participation.

Consumer/Family Member Focus Group 1

CalEQRO requested a culturally diverse group of adult beneficiaries, parents/caregivers of child/youth beneficiaries, and transitional age youth beneficiaries including a mix of existing and new clients who have initiated/utilized services within the past 12 months. The focus group participants consisted of English-speaking adult consumers. The focus group was held at the Circle of Native Minds wellness center in Lakeport.

Number of participants: 5

Only one participant entered service within the past year, so their information is incorporated into that below to protect consumer confidentiality.

General comments regarding service delivery that were mentioned included the following:

- Helpful and positive.
- Having improved over the past year
- Accessible and responsive to their requests
- Accommodating their interest to share their recovery experiences

Recommendations for improving care included the following:

- Coordinate with FSPs to ensure acceptance of referred consumers.

Interpreter used for focus group 1: No Language: Not Applicable

Consumer/Family Member Focus Group Findings—Implications

Access to Care

- Participants reported satisfactory access to a variety of services including case management, medications, therapy, and crisis support.
- Participants indicated that the Bridge Drop-in Center was an added resources and facilitated access that could prevent crises.

Timeliness of Services

- Participants reported satisfaction with the timeliness of services.

Quality of Care

- Participants were not familiar with—and did not know—that the MHP had a warm line. When needed, participants reported that they use a warm line provided through another county.

Consumer Outcomes

- MHP staff were influential in encouraging consumers to seek and secure employment opportunities for those with lived experience.
- Participants expressed involvement in the development of their own treatment plans.

INFORMATION SYSTEMS REVIEW

Understanding an MHP's information system's capabilities is essential to evaluating its capacity to manage the health care of its beneficiaries. CalEQRO used the written response to standard questions posed in the California-specific ISCA, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

Key Information Systems Capabilities Assessment (ISCA) Information Provided by the MHP

The following information is self-reported by the MHP through the ISCA and/or the site review.

Table 9 shows the percentage of services provided by type of service provider.

Table 9: Distribution of Services, by Type of Provider

Type of Provider	Distribution
County-operated/staffed clinics	75%
Contract providers	25%
Network providers	0%
Total	**100%**

Percentage of total annual MHP budget dedicated to supporting information technology operations (includes hardware, network, software license, and IT staff): 5%

The budget determination process for information system operations is:

☐ Under MHP control
☐ Allocated to or managed by another County department
☒ Combination of MHP control and another County department or Agency

MHP currently provides services to consumers using a telepsychiatry application:

☒ Yes ☐ No ☐ In pilot phase

Number of remote sites currently operational: 2

Identify primary reason(s) for using tele-psychiatry as a service extender (check all that apply):

- ☒ Hiring healthcare professional staff locally is difficult
- ☐ For linguistic capacity or expansion
- ☐ To serve outlying areas within the county
- ☐ To serve consumers temporarily residing outside the county
- ☐ Reduce travel time for healthcare professional staff
- ☐ Reduce travel time for consumers

Telepsychiatry services are available with English and Spanish-speaking practitioners (not including the use of interpreters or language line).

Summary of Technology and Data Analytical Staffing

MHP self-reported technology staff changes (Full-time Equivalent [FTE]) since the previous CalEQRO review are shown in Table 10.

Table 10: Technology Staff

IS FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
3	1	0	0

MHP self-reported data analytical staff changes (in FTEs) that occurred since the previous CalEQRO review are shown in Table 11.

Table 11: Data Analytical Staff

Data Analytical FTEs (Include Employees and Contractors)	# of New FTEs	# Employees / Contractors Retired, Transferred, Terminated	Current # Unfilled Positions
6	3	0	1

The following should be noted with regard to the above information:

- The MHP is actively examining its need for clinical data analytics staff. To supplement and inform current resources the MHP has contracted with IDEA Consulting to provide insight and capacity.

Current Operations

- The MHP continues to use a locally hosted and county IT supported EHR system. Despite the small size of the MHP, this local hosting creates a development burden for MHP and IT staff, which might be more conservatively managed via an Application Service Provider (ASP) model system.
- The MHP was able to accomplish significant infrastructure upgrades to its EHR (hardware and software) that has materially improved performance for End Users.

Table 12 lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SDMC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Table 12: Primary EHR Systems/Applications

System/Application	Function	Vendor/Supplier	Years Used	Operated By
CCBH	EHR	Cerner	10	County IT

Priorities for the Coming Year

- ASAM Assessment (AODS)
- Merge/combine MH Adult & Child Assessments, include ACES and other important data
- Revamp Mental Health Brief Intake Screening, include Beacon Referral questions to coordinate
- Cost Report setup for AODS
- Full Document Management – Anasazi (already implemented Labs, Hospital and Legal)
- Full Audit Logging after new Anasazi Server
- HIPAA Forms into Anasazi

- Network of Care Trilogy System-eLearning/Management/Database/Referral System
- Review New EHR
- Staff Training – update training manual

Major Changes Since Prior Year

- New Anasazi Physical Server
- Crisis Assessment Restructure
- LCBH Resource Website
- DSM-V changes effective 4/01/17

Other Significant Issues

- The MHP's staffing issues (executive, quality improvement, and clinical) during the past couple of years have led to a rather fragile environment for the agency's oversight and analytics capabilities. It is currently difficult, with present staffing levels, to reinstitute previous analytics capabilities. While the MHP is endeavoring to make adjustments, such as bringing on outside analytics consultants, it is unclear if the MHP is simply getting back capabilities or if it is remediating systems and protocols to foster robust and resilient protocols. Some easy analyses, such as a basic capacity analysis, could also help the MHP to gain valuable intelligence on clinical staffing levels.
- The newly refreshed QIC has not, as yet, had sufficient time to do a comprehensive review of the regular data analytics that it must produce (e.g.; penetration rates or service flow to measure service demand, Level of Service/Level of Care longitudinal analysis to measure program effectiveness, etc.) to inform the executive team so that they can provide effective leadership.
- While the MHP has made significant strides in improving IT infrastructure it has not kept abreast of monitoring HIPAA compliance for its contractors. This should be done soon. IT staff also noted that they have not recently run a test of their business continuity plans to assess the viability of training and resources to support the EHR in case of an emergency.

- While the MHP was exploring Health Information Exchange (HIE) projects a couple of years ago with relevant service partners, it currently has no plans in process to use its EHR for this purpose.

Plans for Information Systems Change

- The MHP is actively searching for a new system. The MHP expressed concerns with the manner in which the current vendor, Cerner, is moving forward with their product upgrade cycle and the MHP has decided to examine alternatives.

Current Electronic Health Record Status

Table 13 summarizes the ratings given to the MHP for EHR functionality.

Table 13: EHR Functionality

Function	System/ Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Alerts				x	
Assessments		x			
Care Coordination				x	
Document imaging/storage		x			
Electronic signature—consumer		x			
Laboratory results (eLab)				x	
Level of Care/Level of Service			x		
Outcomes		x			
Prescriptions (eRx)		x			
Progress notes		x			
Referral Management				x	
Treatment plans		x			
Summary Totals for EHR Functionality		**7**	**1**	**4**	**0**

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- While the MHP has some outcomes tools embedded in their EHR (e.g.; MORS, CANS) they are not utilizing this data set for longitudinal system-wide secondary analysis to inform management.

Consumer's Chart of Record for county-operated programs (self-reported by MHP):

☐ Paper ☐ Electronic ☒ Combination

Personal Health Record

Do consumers have online access to their health records either through a Personal Health Record (PHR) feature provided within the EHR, consumer portal, or third-party PHR?

☐ Yes ☒ No

If no, provide the expected implementation timeline.

☐ Within 6 months	☐ Within the next year
☐ Within the next two years	☒ Longer than 2 years

Medi-Cal Claims Processing

MHP performs end-to-end (837/835) claim transaction reconciliations:

☒ Yes ☐ No

If yes, product or application:

While the MHP did use the Dimension Reports product it ceased this activity and is now relying on local staff to perform this activity manually.

Method used to submit Medicare Part B claims:

☐ Paper ☐ Electronic ☒ Clearinghouse

Table 14 summarizes the MHP's SDMC claims.

Table 14: Lake MHP Summary of CY16 Short Doyle/Medi-Cal Claims

Number Submitted	Gross Dollars Billed	Number Denied	Dollars Denied	Percent Denied	Gross Dollars Adjudicated	Claim Adjustments	Gross Dollars Approved
19,387	$3,865,962	**997**	$180,261	4.66%	$3,685,701	$195,429	$3,490,272

Note: Includes services provided during CY16 with the most recent DHCS processing date of May 19, 2017

Table 15 summarizes the most frequently cited reasons for claim denial.

Table 15: Lake MHP Summary of CY16 Top Three Reasons for Claim Denial			
Denial Reason Description	Number Denied	Dollars Denied	Percent of Total Denied
Service Facility Location provider NPI not eligible	478	$69,705	39%
Other coverage must be billed prior to submission of this claim	327	$62,905	35%
Missing, incomplete, invalid ICD-10 diagnosis or condition	159	$27,868	15%
Total Denied Claims	997	$180,261	100%

Information Systems Review Findings—Implications

Access to Care

- The QI team needs to work with management to produce an inventory of regular analytics that they should monitor to provide the executive team with intelligence to appropriately cope with access to service issues.

Timeliness of Services

- The MHP needs to continue closely monitoring its use of telepsychiatry services to ensure a good fit between the services delivered by the vendor and the operational requirements for timely and cost-effective services required by the MHP.

Quality of Care

- The MHP has made significant strides in improving its electronic health record infrastructure. This has stabilized end user performance to improve care.
- The MHP needs to consider how the staffing tumult of the past few years has operationally affected the MHP's ability to serve consumers. A basic capacity analysis conducted by the QIC may provide valuable insight to programmatic ability to provide quality care.
- The MHP's compliance team does not seem to be conducting HIPAA reviews of its contractors often enough. The team is not holding County IT accountable for conducting tests of disaster recovery plans on a regular basis.

- The MHP is not currently pursuing Health Information Exchange projects with relevant service partners such as local hospitals or Mild to Moderate providers.

Consumer Outcomes

- For a variety of reasons, the MHP is not currently able to leverage its outcomes tools to conduct meaningful longitudinal secondary analyses to provide level of service/level of care determinations at the consumer, staff, program, and underserved population levels.

SITE REVIEW PROCESS BARRIERS

The following conditions significantly affected CalEQRO's ability to prepare for and/or conduct a comprehensive review:

- No barriers were encountered during this review.

CONCLUSIONS

During the FY17-18 annual review, CalEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CalEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access to and timeliness of services and improving the quality of care.

Strengths and Opportunities

Access to Care

Strengths:

- The MHP has a few resources that have supplemented consumers' access to services when the MHP had limited capacity, including the wellness centers, community agencies, and contract providers.

Opportunities:

- The negative impact of the staffing shortfall, particularly on outpatient services, was anecdotal and also not endorsed by all stakeholders. The MHP needs empirical evidence of the impact of staffing on access to services across their entire system of care.
- MHP leadership reported dissatisfaction with the telepsychiatry vendor and that services and access were sometimes a detriment for the MHP. Other telepsychiatry providers are on the market and the MHP might benefit from a targeted review of this vendor's services compared to others.

Timeliness of Services

Opportunities:

- Besides rehospitalization, the MHP could not provide any data on the timeliness to services in the past year. The MHP is not in a position to know if access to services are timely or not.

Quality of Care

Strengths:

- The MHP has made significant strides in improving the electronic health record infrastructure. This has stabilized end user performance to improve care.
- The MHP has contract providers who are interested in collaborating on PIPs. These contract providers have drawn from their experience in collaborating with other MHPs from neighboring counties on their PIPs.
- The MHP's new leadership has brought a sense of transparency and willingness to engage stakeholders.

Opportunities:

- The MHP has a number of staff who have tenure with Lake County Behavioral Health and who have undergone a number of initiatives, but new leadership has yet to draw upon or solicit their input.
- The MHP has a higher percentages of psychosis, other, and deferred diagnoses than statewide percentages, and a lower percentage of all other diagnostic categories than statewide. The MHP should consider the financial impact and potential loss of revenue with high numbers of these non-specific diagnoses.
- Change fatigue was expressed by a number of stakeholders and should be a consideration of leadership as they implement projects and re-establish processes and protocols.
- The MHP is not currently pursuing an HIE project with relevant service partners.

Consumer Outcomes

Strengths:

- MHP staff use validated outcome measures as a regular part of their care, but staff are amenable to other outcome measures that are more specific and with greater frequency of application.

Opportunities:

- Staff must seek out and obtain external training for evidenced-based practices that the MHP or specific programs endorse because of their impact on consumer outcomes.
- The MHP is not currently able to leverage its outcomes tools to conduct meaningful longitudinal secondary analyses to provide Level of Service/Level of Care information to the management team.

Recommendations

- Resume tracking and monitoring of the timeliness metrics on the Self-Assessment of Timely Access, for both adult and children's system of care, and conduct a review of these metrics, minimally, every quarter.
- Conduct a formal, documented capacity analysis that compares current staffing with demand across the entire system of care. Once completed, use this information to begin to adjust or target staffing.
- Produce an inventory of regular analytics that are automated and monitored routinely that provide the executive team with information about access to services that relate more to quality and wellness and less on compliance.
- Develop a performance improvement project (PIP) timeline for both the clinical and non-clinical PIP, which has quarterly benchmarks that are consistent with the major components of a PIP (e.g., identification of a project with data to substantiate a problem needing improvement; identification and implementation of interventions; data collection and oversight of the interventions; and data analysis). Consult CalEQRO as necessary to provide technical assistance.
- Revise the quality improvement (QI) work plan to include standing membership by supervisory staff, with accompanying minutes to reflect both attendance and involvement of supervisory staff in QI activities.

ATTACHMENTS

Attachment A: CalEQRO On-site Review Agenda

Attachment B: On-site Review Participants

Attachment C: Approved Claims Source Data

Attachment D: CalEQRO Performance Improvement Plan (PIP) Validation Tools

Attachment A—On-site Review Agenda

The following sessions were held during the MHP on-site review, either individually or in combination with other sessions.

Table A1—EQRO Review Sessions - Lake MHP
Opening Session – Changes in the past year; current initiatives; and status of previous year's recommendations
Use of Data to Support Program Operations
Disparities and Performance Measures/ Timeliness Performance Measures
Quality Improvement and Outcomes
Performance Improvement Projects
Primary and Specialty Care Collaboration and Integration
Health Plan and Mental Health Plan Collaboration Initiatives
Clinical Line Staff Group Interview
Clinical Supervisors Group Interview
Consumer Family Member Focus Group(s)
Contract Provider Group Interview – Administration and Operations
Contract Provider Group Interview – Quality Management
Validation of Findings for Pathways to Mental Health Services (Katie A./CCR)
ISCA/Billing/Fiscal
EHR Deployment
Tele Mental Health
Wellness Center Site Visit

Attachment B—Review Participants

CalEQRO Reviewers

Ewurama Shaw – Taylor, PhD, Lead Reviewer
Duane Henderson, Information Systems Reviewer
Luann Baldwin, Consumer/Family Member Consultant

Additional CalEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and in preparing the recommendations within this report.

Sites of MHP Review

MHP Sites

Lake County Behavioral Health, South Lake Office
7000-B South Center Drive
Clearlake, CA 95422

Circle of Native Minds
845 Bevins Street
Lakeport, CA 95453

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Metcalf	Todd	Acting Director	Lake County Behavioral Health (LCBH)
Kammersgard	Eric	Deputy Administrator	LCBH
Drukala	Christina	Clinical Team Lead	LCBH
Wilson	Stephanie	Mental Health Team Leader	LCBH
Isherwood	James	Mental Health Team Leader	LCBH
Pimenta	Carolina	Mental Health Team Leader	LCBH
Page	Kelli	Staff Services Analyst, Sr.	LCBH
Larsen	Kelly	Business Software Analyst	LCBH
Kitchens	Rachel	Supervising Accountant	LCBH
Warner	Lisa	Managed Care Administrative Coordinator	LCBH
Lamkin	Michelle	Staff Services Specialist	LCBH
Chappel	Jolene	Program Manager	Redwood Community Services (RCS)
Kelly	Victoria	Program Director	RCS
Mondrrans	Wendy	Chief Deputy	Probation
O'Brien	Kevin	Senior Deputy	Probation
Powell	Patti	Deputy Director	Child Welfare Services
Santana	Ana	Director, Healthy Start/Safe Schools	Lake County Office of Education
French	Shane	IT Director	Lake County IT
Roseneau	Sheila	MHSA Coordinator	LCBH
Padilla	Socorro	Therapist	LCBH
Drinnon	Clay	Case Manager	LCBH

Table B1 - Participants Representing the MHP			
Last Name	**First Name**	**Position**	**Agency**
Braley	Denyel	Case Manager	LCBH
Wolfley	Janet	Mental Health Nurse	LCBH
Boyce	Kendra	Prevention Specialist	LCBH
Neria	Zabdy	Case Manager	LCBH
Trillo	Jamie	Specialist II, Therapist	LCBH
Street	Mike	Specialist II, Therapist	LCBH
Hutchins	Gina	Case Manager	LCBH
Giambra	April	Alcohol and Other Drugs Program Coordinator	LCBH

Attachment C—Approved Claims Source Data

Approved Claims Summaries are provided separately to the MHP in a HIPAA-compliant manner. Values are suppressed to protect confidentiality of the individuals summarized in the data sets where beneficiary count is less than or equal to eleven (*). Additionally, suppression may be required to prevent calculation of initially suppressed data, corresponding penetration rate percentages (n/a); and cells containing zero, missing data or dollar amounts (-).

Table C1 shows the penetration rate and approved claims per beneficiary for just the CY16 ACA Penetration Rate and Approved Claims per Beneficiary. Starting with CY16 performance measures, CalEQRO has incorporated the ACA Expansion data in the total Medi-Cal enrollees and beneficiaries served.

Table C1: Lake MHP CY16 Medi-Cal Expansion (ACA) Penetration Rate and Approved Claims per Beneficiary

Entity	Average Monthly ACA Enrollees	Number of Beneficiaries Served	Penetration Rate	Total Approved Claims	Approved Claims per Beneficiary
Statewide	3,674,069	137,620	3.75%	$599,045,852	$4,353
Small	169,682	6,634	3.91%	$23,428,744	$3,532
Lake	8,801	211	2.40%	$977,242	$4,631

Table C2 shows the distribution of the MHP beneficiaries served by approved claims per beneficiary (ACB) range for three cost categories: under $20,000; $20,000 to $30,000, and those above $30,000.

Table C2: Lake MHP CY16 Distribution of Beneficiaries by ACB Range

Range of ACB	MHP Count of Beneficiaries Served	MHP Percentage of Beneficiaries	Statewide Percentage of Beneficiaries	MHP Total Approved Claims	MHP Approved Claims per Beneficiary	Statewide Approved Claims per Beneficiary	MHP Percentage of Total Approved Claims	Statewide Percentage of Total Approved Claims
< $20K	997	94.59%	93.97%	$3,331,092	$3,341	$3,636	61.09%	58.96%
>$20K - $30K	29	2.75%	2.87%	$689,430	$23,773	$24,284	12.64%	12.02%
>$30K	28	2.66%	3.16%	$1,432,413	$51,158	$53,219	26.27%	29.02%

Attachment D—PIP Validation Tools

PERFORMANCE IMPROVEMENT PROJECT (PIP) VALIDATION WORKSHEET FY17-18	CLINICAL PIP
GENERAL INFORMATION	
MHP: Lake County	
PIP Title: Transition Team	
Start Date (MM/DD/YY): 01/01/17 **Completion Date** (MM/DD/YY): 12/31/18 **Projected Study Period** (#of Months): 24 **Completed**: Yes ☐ No ☒ **Date(s) of On-Site Review** (MM/DD/YY): 08/17/17 **Name of Reviewer**: Shaw-Taylor	**Status of PIP (Only Active and ongoing, and completed PIPs are rated):** **Rated** ☐ Active and ongoing (baseline established and interventions started) ☐ Completed since the prior External Quality Review (EQR) **Not rated. Comments provided in the PIP Validation Tool for technical assistance purposes only.** ☒ Concept only, not yet active (interventions not started) ☐ Inactive, developed in a prior year ☐ Submission determined not to be a PIP ☐ No Clinical PIP was submitted
Brief Description of PIP (including goal and what PIP is attempting to accomplish): In December 2016, the MHP noticed a trend that clients returning to the county, after placements outside of Lake county (e.g., at IMDs), were not linked to needed services in a timely fashion. In addition to delayed access, consumers had repeat hospitalizations, subsequent to decompensation. The MHP attributed the disruption and delay in services to ongoing staffing	

shortages. The MHP developed a multi-disciplinary transition team to facilitate linkage to services and prevent rehospitalization. The transition team will coordinate medication support, housing, the wellness centers, and other needed services.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

STEP 1: Review the Selected Study Topic(s)

Component/Standard	Score	Comments
1.1 Was the PIP topic selected using stakeholder input? Did the MHP develop a multi-functional team compiled of stakeholders invested in this issue?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP team includes a broad range of stakeholders, primarily MHP staff, who have experience and expertise in coordinating integrated care and services for consumers. The PIP team lacks consumer input, either directly from a consumer or from a consumer advocate.
1.2 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP provided rehospitalization rate of 31% from July 2015 – December 2015. Given that the project started in January 2017, the MHP should provide more current data from July 2016 – December 2016 to confirm that, indeed, they continue to have high a rehospitalization rate. The data that the MHP provides should also include or parse out conserved individuals and their contribution to the rehospitalization rate.
Select the category for each PIP: *Clinical:* ☐ Prevention of an acute or chronic condition ☐ High volume services ☐ Care for an acute or chronic condition ☒ High risk conditions	*Non-Clinical:* ☐ Process of accessing or delivering care	
1.3 Did the Plan's PIP, over time, address a broad spectrum of key aspects of enrollee care and services? *Project must be clearly focused on identifying and correcting deficiencies in care or services, rather than on utilization or cost alone.*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The premise of the PIP is that a multi-disciplinary team can facilitate connections and services for high need consumers, but the MHP did not provide sufficient information that connections to services (e.g., housing, follow-up appointments, wrap-around services, etc.) contributed to the rehospitalization rate in the first place.

1.4 Did the Plan's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP is focused on rehospitalizations and thus would target all consumers who have at least one hospitalization during the study period.
Totals		**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 2: Review the Study Question(s)		
2.1 Was the study question(s) stated clearly in writing? Does the question have a measurable impact for the defined study population? *Include study question as stated in narrative:* Would creation of a multi-disciplinary team facilitate connection to and engagement in identified services such that a conserved client returning from an out-of-county IMD placement or a Board and Care or a high user of hospitalizations, result in increased stability within the community as measured by a reduction in hospitalizations for the client and an increased participation in services?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study question is stated clearly; however, the study question would benefit from specific targets for improvement. How much of a reduction in hospitalizations is desired? How much of an increase in participation in services is needed?
Totals		**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 3: Review the Identified Study Population		
3.1 Did the Plan clearly define all Medi-Cal enrollees to whom the study question and indicators are relevant? *Demographics:* ☐ Age Range ☐ Race/Ethnicity ☐ Gender ☐ Language ☐ Other	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP indicated two populations for the study: (1) conserved clients placed out-of-county and (2) clients who are frequently hospitalized. The MHP provided a number of 21 for conserved clients, but did not provide a number of consumers who are frequently hospitalized who are most likely to contribute to the rehospitalization rate.

3.2 If the study included the entire population, did its data collection approach capture all enrollees to whom the study question applied? *Methods of identifying participants:* ☐ Utilization data ☐ Referral ☐ Self-identification ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The PIP document did not articulate a plan for data collection and inclusion of participants. The MHP will need to articulate a plan for if and when consumers opt out of the transition team support, given that it is a voluntary program.
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 4: Review Selected Study Indicators		
4.1 Did the study use objective, clearly defined, measurable indicators? *List indicators:* 1. Hospitalizations 2. Placements	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The study identifies two indicators, hospitalization (rate) and placements. The MHP needs to adjust the time period to be prospective, rather than retrospective (from 7/2015 – 12/2015). The MHP also needs other indicators, including an indicator for: 1. Participation in services (which is part of the study question) 2. Timeliness of coordination (which was presented as problematic) 3. Duration of stay with transition team
4.2 Did the indicators measure changes in: health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? All outcomes should be consumer focused. ☒ Health Status ☒ Functional Status ☐ Member Satisfaction ☐ Provider Satisfaction Are long-term outcomes clearly stated? ☐ Yes ☐ No Are long-term outcomes implied? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	At present, these indicators measure a change in functional status (i.e., maintaining placements) and health status (i.e., reduced hospitalizations). The MHP should articulate the long-term outcomes (to consumers) of this improvement project.
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD

STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the: a) True (or estimated) frequency of occurrence of the event? b) Confidence interval to be used? c) Margin of error that will be acceptable?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	As the MHP intends to include/offer the program to all conserved and returning clients, sampling is not necessary.
5.2 Were valid sampling techniques that protected against bias employed? *Specify the type of sampling or census used:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	No sampling.
5.3 Did the sample contain a sufficient number of enrollees? _____N of enrollees in sampling frame _____N of sample _____N of participants (i.e. – return rate)	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	No sampling.
Totals		**<#>** Met **<#>** Partially Met **<#> N**ot Met <#> NA **<#>** UTD
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide information on the data to be collected.
6.2 Did the study design clearly specify the sources of data? *Sources of data:* ☐ Member ☐ Claims ☐ Provider ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide information on the data to be collected.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide information on the data to be collected.
6.4 Did the instruments used for data collection provide for consistent, accurate data collection over the time periods studied? *Instruments used:* ☐ Survey ☐ Medical record abstraction tool ☐ Outcomes tool ☐ Level of Care tools ☐ Other: <Text if checked>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide information on the data to be collected.
6.5 Did the study design prospectively specify a data analysis plan? Did the plan include contingencies for untoward results?	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide a data analysis plan.
6.6 Were qualified staff and personnel used to collect the data? *Project leader:* Name: <Text> Title: <Text> Role: <Text> *Other team members:* Names: <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide information on who is to collect the data.
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD

STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? *Describe Interventions:* *<Text>*	☐ Met ☐ Partially Met ☐ Not Met ☐ Unable to Determine	The MHP did not provide sufficient information about the conserved and/or high need clients to determine that a treatment team to coordinate care was the solution to the rehospitalization rate. The MHP did not list their interventions. Elsewhere in the PIP document, the MHP indicated that they would: 1. Meet twice per month to review pending discharges 2. Form a transition team 3. Meet with and provide linkages to services for clients
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** UTD
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? *This element is "Not Met" if there is no indication of a data analysis plan (see Step 6.5)*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
8.2 Were the PIP results and findings presented accurately and clearly? Are tables and figures labeled? ☐ Yes ☐ No Are they labeled clearly and accurately? ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? Indicate the time periods of measurements: _____ Indicate the statistical analysis used: _____ Indicate the statistical significance level or confidence level if available/known: _____% _____Unable to determine	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
8.4 Did the analysis of the study data include an interpretation of the extent to which this PIP was successful and recommend any follow-up activities? *Limitations described:* <Text> *Conclusions regarding the success of the interpretation:* <Text> *Recommendations for follow-up:* <Text>	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** NA **<#>** UTD
STEP 9: Assess Whether Improvement is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement used when measurement was repeated? *Ask: At what interval(s) was the data measurement repeated?* *Were the same sources of data used?* *Did they use the same method of data collection?* *Were the same participants examined?* *Did they utilize the same measurement tools?*	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.

9.2 Was there any documented, quantitative improvement in processes or outcomes of care? Was there: ☐ Improvement ☐ Deterioration Statistical significance: ☐ Yes ☐ No Clinical significance: ☐ Yes ☐ No	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
9.3 Does the reported improvement in performance have internal validity; i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention? *Degree to which the intervention was the reason for change:* ☐ No relevance ☐ Small ☐ Fair ☐ High	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? ☐ Weak ☐ Moderate ☐ Strong	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
9.5 Was sustained improvement demonstrated through repeated measurements over comparable time periods?	☐ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable ☐ Unable to Determine	The MHP is not at this stage of the PIP.
	Totals	**<#>** Met **<#>** Partially Met **<#>** Not Met **<#>** NA **<#>** UTD

ACTIVITY 2: VERIFYING STUDY FINDINGS (OPTIONAL)

Component/Standard	Score	Comments
Were the initial study findings verified (recalculated by CalEQRO) upon repeat measurement?	☐ Yes ☐ No	

ACTIVITY 3: OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS		
Conclusions: <Text>		
Recommendations: <Text>		
Check one:	☐ High confidence in reported Plan PIP results	☐ Low confidence in reported Plan PIP results
	☐ Confidence in reported Plan PIP results	☐ Reported Plan PIP results not credible
	☐ Confidence in PIP results cannot be determined at this time	